TENNESSEE ORTHOPAEDIC CLINICS

MRN#

Patient Information				
Name (Last, First, Middle)		SSN#	Date of Birth	Sex
Address			City State Zip	
Mobile Phone	Home Phone	Language	Race	Ethnicity
Email	Referring Physician		Primary Care Provider	
Secondary Billing Address			City, State, Zip	
Marital Status	Student Status	Emergency Contact Name	Emergency Contact home	
Primary Employer			Work Phone	
Address			City, State, Zip	

Responsible Party Information (If Different from Above)				
Name (Last, First, Middle)		SSN#	Date of Birth	Sex
Address			City, State, Zip	
Mobile Phone	Home Phone	Language	Race	Ethnicity
Email		Marital Status	Relationship to Patient	
Secondary Billing Address			City, State, Zip	

Primary Insurance		
Name of Insurance Company		Policy #
Name of Insured		Group#
Address of Insurance company		COPAY Amount
City, State, Zip	Phone	Deductible Amount
Relationship to Patient	Plan Effective Date	Plan Expiration Date

Secondary Insurance (if Applicable)		
Name of Insurance Company		Policy #
Name of Insured		Group#
Address of Insurance company		COPAY Amount
City, State, Zip	Phone	Deductible Amount
Relationship to Patient	Plan Effective Date	Plan Expiration Date

Signature	Date

TENNESSEE ORTHOPAEDIC CLINICS

COMMUNICATION OF PRIVATE HEALTH INFORMATION FORM

I_____ give TOC permission to disclose my health information and account information to: please list all parties, including yourself if patient is a minor, we may discuss this information with (spouse, other family members, etc.) *Please give full names*.

_____ _____

_____ _____

_____ _____

WHERE AND HOW MAY WE CONTACT YOU?

HOME	☐	**YES**	**IF YES – Please provide number**
	☐	**NO**	_____
WORK	☐	**YES**	**IF YES – Please provide number**
	☐	**NO**	_____
EMAIL	☐	**YES**	**IF YES – Please provide email**
	☐	**NO**	_____
CELL	☐	**YES**	**IF YES – Please provide cell number**
	☐	**NO**	_____
TEXT	☐	**YES**	**IF YES – Please provide cell number**
	☐	**NO**	_____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE?

☐ **YES**

☐ **NO**

MAY WE LEAVE A MESSAGE AT HOME OR WORK, IF YOU DO NOT HAVE A MACHINE?

☐ **YES**

☐ **NO**

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

Created 2.14.18 KP

TENNESSEE ORTHOPAEDIC CLINICS

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any medical information necessary for the processing of insurance claims. I hereby assign all medical benefits to include major medical benefits to which I am entitled to Tennessee Orthopaedic Clinics, P.C. this will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I further agree to be solely responsible for any balances that my insurance does not pay.

SIGNATURE: _____ Date: _____

REFERRAL INFORMATION:

I understand that if a referral is required by my primary physician, I am responsible for obtaining this referral and following the rules/regulations of my insurance provider. I understand that failure to obtain my referral could result in my responsibility for payment of services rendered.

SIGNATURE: _____ Date: _____

In the event this account is turned over for collection, patient (or responsible party) agrees to pay for all costs of collections, including court costs and attorney's fees.

SIGNATURE: _____ Date: _____

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as (1) any cell, landline, or text number that I provide (2) Any email address that I provide (3) auto dialer systems (4) voicemail messages and other forms of communication.

SIGNATURE: _____ Date: _____

INFORMED CONSENT FOR OPIOID TREATMENT FOR ACUTE PAIN
Tennessee Orthopaedic Clinics, P.C.

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. You should understand that your physician or PA/NP may recommend non-opioid treatment of your acute pain with options including but not limited to: No active intervention, local modalities such as ice and/or heat, physical therapy, or non-opioid medications such as acetaminophen or nonsteroidal anti-inflammatory medications, etc. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids (morphine-like drugs) as part of my treatment for acute pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/ health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. I am responsible for my pain medications. I agree to take the medication only as prescribed.
   a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.
   b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at TOC.

3. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

   It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.

4. I understand that the opioid medication is strictly for my own use. The opioid should never be given or sold to others because it may endanger that person's health and is against the law.

5. I should inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.

6. I understand that my narcotic treatment will continue for no more than 60 days after surgery. If I require narcotic management for a longer period of time, I will be referred to the Pain Specialist of my choice.

7. I understand a written prescription will be necessary and I will need to be seen by the physician or PA/NP in order to obtain that prescription).

8. Any evidence of drug hoarding, acquisition of any opioid medication or additional narcotic pain medications from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

9. I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust your treatment plan accordingly.

10. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

11. The use of alcohol together with opioid medications is contraindicated.

12. I am responsible for my opioid prescriptions. I understand that:
    a. Refill prescriptions will be filled at the same pharmacy. *See back page to select your preferred pharmacy.*
    b. It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.
    c. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, or stolen my physician may choose not to replace the medications or to taper and discontinue the medications.
    d. Refills will not be made as an “emergency”, such as on Friday afternoon because I suddenly realize I will “run out tomorrow”.
    e. Refills can only be filled by a pharmacy in the State of Tennessee, even if I am a resident of another state.
    f. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. **No** refills of any medications will be done during the evening or on weekends.
    g. I agree to keep all scheduled appointments, not just with your physician, but also with the recommended therapist. Two or more missed appointments or same day cancellations may lead to patient dismissal.
    h. Prescription refills may be authorized during regular working hours before 3:30 PM. If I need a narcotic prescription, I have to pick the prescription up at the TOC office and will need to call two days in advance of the renewal date. (Non-narcotic prescriptions will be ready the next day at the pharmacy.)
    i. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
    j. If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments will not be granted as a rule; exceptions will be made on a case by case basis.
    k. No “walk-in” appointments for opioid refills will be granted.

13. While physical dependence is to be expected after long-term use of opioids, signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.
    a. Physical dependence is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.
    b. Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.
    c. Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.

14. If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

15. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a necessity.

16. I agree to fully comply with all aspects of my treatment program including physical therapy, if recommended. Failure to do so may lead to discontinuation of my medication.

17. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

18. I agree to allow my physician/health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the physician feels it is necessary*.

19. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

20. I have had a reasonable opportunity to have my questions regarding treatment with opioids asked and answered.

In addition, use of these medications poses special risk to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medication, I will immediately call my obstetrician or primary care physician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication; the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development that was exposed opioids is not understood. If you have questions regarding contraceptive methods please see your primary care physician, OB/GYN specialist, or the local health department.

If you develop complications of opioid use, such as addiction, we will assist you in finding treatment. Please be aware, however, that our practice cooperates fully with local and state law enforcement, the US Drug Enforcement Agency and other agencies in the investigation of opioid related crimes including sharing, selling, trading or other potential harmful use of these powerful medications.

I _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient's Signature_____Date_____

Witness's Signature_____Date_____

Pharmacy Name_____Pharmacy Phone Number___ _____

TENNESSEE ORTHOPAEDIC CLINICS

NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

PLEASE REVIEW IT CAREFULLY

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices to review and have therefore been advised that my private health information may be used to seek payment for my medical treatment and services, as well as clinic practice operations.

Tennessee Orthopaedic Clinics participates in East Tennessee Health Information Network (etHIN) through which private health information is exchanged between health care providers electronically. Your private health information may be exchanged with your healthcare providers through etHIN.

I understand how I may obtain access to and control this information. I also acknowledge and understand that I may request a hard copy, or copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and certain reproductive health information, and that it will be provided to me if I do request it.

_____ _____
Patient's signature Date

_____ _____
Legal or Personal Representative of Patient (if applicable) Relationship

This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act (ADA).

Full privacy policy posted under patient information at www.tocdocs.com

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fax (865) 694-7907

TENNESSEE ORTHOPAEDIC CLINICS

Injury Details:

Please provide a brief description of the reason for your visit today:

Was the reason for your visit caused by a motor vehicle accident? ☐ Yes ☐ No

Was the reason for your visit caused by a work related incident? ☐ Yes ☐ No

Are you currently seeing any of the following for this problem?

☐ Physician ☐ Therapist ☐ Chiropractor ☐ Podiatrist ☐ Pain Clinic ☐ Other ☐ None

Past Medical History – Have you ever had any of the following medical conditions?

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
  - ☐ Breast
  - ☐ Lung
  - ☐ Myeloma
  - ☐ Prostate
  - ☐ Renal
  - ☐ Skin
  - ☐ Other
- ☐ Cardiac Pacemaker/ Defibrillator
- ☐ Cardiomyopathy
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes Type 1
  Select most recent A1c result if known?
  ☐ <6 ☐ 6-7 ☐ 7.1-8 ☐ 8.1-8.9 ☐ >9
- ☐ Diabetes Type 2
  Select most recent A1c result if known?
  ☐ <6 ☐ 6-7 ☐ 7.1-8 ☐ 8.1-8.9 ☐ >9
- ☐ Diverticulitis
- ☐ DVT/Blood Clot
- ☐ Emphysema/COPD
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lymphedema
- ☐ Kidney Transplant
- ☐ Lupus
- ☐ Metal/Nickel Allergy
- ☐ Mini-Strokes
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolus
- ☐ Renal Failure
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
  - ☐ Overactive
  - ☐ Underactive
- ☐ Ulcer Disease
- ☐ MRSA (Staph Infection)
- ☐ AIDS/HIV
- ☐ Latex Allergy
- ☐ Aortic Stenosis

Other Relevant Medical History:

☐ **None of the above applies**

Past Surgical History – Please mark all that applies.

- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Breast Biopsy
- ☐ Cataracts
- ☐ Gall Bladder
- ☐ Heart Bypass
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Tonsillectomy
- ☐ Tubes Tied
- ☐ Vasectomy
- ☐ Carpal Tunnel ☐ R ☐ L
- ☐ Hip Replacement ☐ R ☐ L
- ☐ Hip Revision ☐ R ☐ L
- ☐ Foot/Ankle Surgery ☐ R ☐ L
- ☐ Knee Arthroscopy ☐ R ☐ L
- ☐ Knee Replacement ☐ R ☐ L
- ☐ Knee Revision ☐ R ☐ L
- ☐ Partial Knee Replacement ☐ R ☐ L
- ☐ Shoulder Replacement ☐ R ☐ L
- ☐ Rotator Cuff Repair ☐ R ☐ L
- ☐ Spine Surgery

Additional Surgeries/Details:

☐ **None of the above applies**

Review of Systems – Please mark all that applies.

Constitutional
- ☐ Unexplained Weight Loss
- ☐ Fever/Chills
- ☐ Night Sweats

Allergy/Immunologic
- ☐ Frequent Colds, Infections, Allergies
- ☐ Hives

Hematologic/Lymphatic
- ☐ Easy Bruising or Bleeding
- ☐ Lumps (armpit, neck, groin)
- ☐ Anemia

Musculoskeletal
- ☐ Muscle, Bone or Joint Swelling
- ☐ Broken Bones
- ☐ Pain (arm/ leg/ neck/ back)
- ☐ Restless Leg

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Poor Circulation
- ☐ Difficulty Exercising

Eyes
- ☐ Blurry Vision
- ☐ Wear glasses/contacts
- ☐ Blind/Color Blind

Ear, Nose, Throat, Mouth
- ☐ Hearing Problems/Deaf
- ☐ Cannot Taste/Smell
- ☐ Difficulty Swallowing
- ☐ Sore Throat

Endocrine
- ☐ Too Hot/Too Cold
- ☐ Difficult with Stress Mgmt
- ☐ Gland Problems

Genitourinary
- ☐ Difficulty Controlling Bladder
- ☐ Difficulty Urinating
- ☐ Bloody Urine

Respiratory
- ☐ Shortness of Breath
- ☐ Coughing

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool

Neurologic
- ☐ Headache/Dizziness
- ☐ Weakness
- ☐ Numbness

Psychiatric
- ☐ Depression
- ☐ Anxiety

Skin/Breast
- ☐ Rash
- ☐ Hair Loss
- ☐ Bruising
- ☐ Breast Lump

☐ **None of the above applies**

Other/Comments:

Social History – Please respond for each of the following**:**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Alcohol Consumption (per week): ☐ None ☐ 1-3 drinks ☐ 3-4 drinks ☐ more than 6 drinks

Disability Status: ☐ Yes, currently receiving benefits ☐ No, not receiving benefits

Hand Dominance: ☐ Left ☐ Right

Family Medical History – Do any of your immediate relatives have any of the following conditions?
- ☐ Asthma
- ☐ Cancer – Breast
- ☐ Cancer – Colon
- ☐ Cancer – Prostate
- ☐ Cancer - Other
- ☐ Diabetes
- ☐ Pulmonary Embolus (PE)
- ☐ Anesthetic Complication
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease

☐ **None of the above applies**

Other Relevant Family Medical History: